SUMMARY COMPARISON OF MEDICAL PLANS 2014

BENEFIT HIGHLIGHTS	BLUE CROSS BLUE SHIELD PPO		BLUE CROSS BLUE SHIELD PPO PREMIUM		BLUE ADVANTAGE HMO
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
CALENDAR YEAR PLAN DEDUCTIBLE (Paid once in a calendar year)					
Individual	$300	$550	N/A	$350	N/A
Family Maximum	$900	$1,650	N/A	$1,050	N/A
	Deductibles accumulate in and out-of-network				
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includeds deductible & medical co-pays)					
Individual	$1,800	$3,550	Co-pays where applicable	$3,350	$1,500
Family Maximum	$5,400	$10,650	Co-pays where applicable	$7,050	$3,000
	Out-of-pocket max accumulates in and out-of-network includes deductible, medical co-pays, excludes co-pays for Rx		includes deductible, medical co-pays, excludes co-pays for Rx		includes deductible, medical co-pays, excludes co-pays for Rx
DEPENDENT COVERAGE	Adult children may be covered until age 26; Unmarried Military Veteran dependents may be covered until age 30 and must reside in Illinois.				
PHYSICIAN CHARGES					
Office Visits	$20 Co-pay PCP, 100% $30 Co-pay Specialist	80% Subject to deductible	$20 Co-pay, 100% $30 Co-pay Specialist	70% Subject to deductible	$15 Co-pay, 100% PCP $25 Co-pay Specialist
Hospital Visits	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%
Chiropractor	$30 Co-pay, 100%	80% Subject to deductible	$30 Co-pay, 100%	70% Subject to deductible	$25 Co-pay referral from PCP required
Physical Therapy	Non-PCP $30 Co-pay, 100%	80% Subject to deductible	Non-PCP $30 Co-pay, 100%	70% Subject to deductible	$25 Co-pay referral from PCP required
*PCP co-pay will apply to the following physician specialty types: internal medicine, general practitioner, family practice, pediatrician, optometrist, and obstetrician/gynecologist (OB/GYN). Under BCBS PPO & PPO Premium: if your OB/GYN provider is listed as a PCP in the provider directory, you will pay a PCP copayment. If your OB/GYN doctor is listed as a specialist, you will pay the specialist copayment. You do not need a referral to visit an OB/GYN provider.					
DIAGNOSTIC X-RAY AND LAB TESTS					
Billed by Dr. Office	$20 Co-pay, 100%	80% Subject to deductible	100%	70% Subject to deductible	100%
Billed by Other than Dr. Office	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%

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SUMMARY COMPARISON OF MEDICAL PLANS 2014

BENEFIT HIGHLIGHTS	BLUE CROSS BLUE SHIELD PPO		BLUE CROSS BLUE SHIELD PPO PREMIUM		BLUE ADVANTAGE HMO
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
HOSPITAL					
In-Patient	Pre-admission certification is required. Your in-network provider must call Member Services for approval or penalty applies.	Pre-admission certification is required. You must call Member Services for approval or penalty applies.	Pre-admission certification is required. Your in-network provider must call Member Services for approval or penalty applies.	Pre-admission certification is required. You must call Member Services for approval or penalty applies.	Primary care physician must approve hospital stay. $250 co-pay, then 100%
In-Patient Room & Board (Semi-Priva	90% Subject to deductible	80% Subject to deductible	$200 Co-pay, then 100%	70% Subject to deductible	100%
In-Patient Ancillary Charge	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%
Out-Patient Emergency Hospital Charges	90% Subject to deductible	90% Subject to deductible	$100 Co-pay, then 100%	$100 Co-pay, then 100%	$75 Co-pay, then 100%; You must follow the HMO emergency procedure described in the HMO literature.
Urgent Care	90% Subject to deductible	90% Subject to deductible	$100 Co-Pay, 100%	$100 Co-Pay, 100%	$15 Co-pay, then 100% - Urgent Care Center must be affiliated with your Medical Group
SURGERY					
In-Patient	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%
Out-Patient	90% Subject to deductible	80% Subject to deductible	$100 Co-pay, 100%	70% Subject to deductible	$50 Co-pay, 100%
NEWBORN					
Hospital Nursery	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%
Well Baby Care (Office Visit)	100%	Not Covered	100%	Not Covered	100%
PREVENTIVE SERVICES					
Annual Physical Exam	100%	Not Covered	100%	Not Covered	100%
Immunizations & Inoculations	100%	Not Covered	100%	Not Covered	100%
Eye Exams	Blue 365 Discount Program	Not Covered	100% every 24 months	Not Covered	100% every 12 mos. - Davis Vision Provider
Discounts on Glasses	Blue 365 Discount Program	Not Covered	Blue 365 Discount Program	Not Covered	$75 Allowance every 24 mos. - Davis Vision Provider

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SUMMARY COMPARISON OF MEDICAL PLANS 2014

BENEFIT HIGHLIGHTS	BLUE CROSS BLUE SHIELD PPO		BLUE CROSS BLUE SHIELD PPO PREMIUM		BLUE ADVANTAGE HMO
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
MENTAL HEALTH/SUBSTANCE ABUSE					
Office Visits	$20 Co-pay, 100%	80% Subject to deductible	$20 Co-pay	70% subject to deductible	$15 Co-pay, 100%
Hospital In-Patient	90% Subject to deductible	80% Subject to deductible; Precertification required	$200 Co-pay, 100%	70% Subject to deductible; Precertification required	$250 Co-pay, 100%

PRESCRIPTION DRUGS	Generic In-Network	Preferred Brand In-Network	Non-Preferred Brand In-Network	Mail Order (90 Day Supply) In-Network	Out-Of-Network
BLUE CROSS BLUE SHIELD PPO	$10 Co-pay	$20 Co-pay	$40 Co-pay	$20 Co-pay (Generic) $40 Co-pay (Preferred) $80 Co-pay (Non-Preferred)	80% Subject to the Rx deductible of $50
BLUE CROSS BLUE SHIELD PPO PREMIUM	$10 Co-pay	$20 Co-pay	$40 Co-pay	$20 Co-pay (Generic) $40 Co-pay (Preferred) $80 Co-pay (Non-Preferred)	70% Subject to the Rx deductible of $50
BLUE ADVANTAGE HMO	$10 Co-pay	$20 Co-pay	$40 Co-Pay	$20 Co-pay (Generic) $40 Co-pay (Preferred) $80 Co-pay (Non-Preferred)	N/A

EXCLUSIONS AND LIMITATIONS

All services must be medically necessary and are subject to carrier plan rules and limitations. Consult the BCBS Group Insurance Certificate and HMO Contracts and/or booklets for specifics.

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